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APPENDIX

SUBJECT
Person-Centered Recovery Plan Short Form (DPHHS-AMDD-135B) Instructions

PURPOSE

To provide a brief assessment of an individual's need for Home and Community Based Services (HCBS) and to develop a Person-Centered Recovery Plan with the individual to meet his or her short term and/or one time only needs, or residential hospice. The case management team (CMT) completes form DPHHS-SDMI-135B upon initial assessment for individuals enrolled for short-term temporary placement.

This Person-Centered Recovery Plan is an agreement between the individual and the CMT for the provision of short term and/or one time only HCBS services. A discharge plan must be discussed with the individual and documented on this form.

DISTRIBUTION

The CMT retains the suspense (pink) copy in its files while obtaining appropriate signatures on the original and yellow copies. Once these signatures are obtained, the CMT retains the white copy and sends the yellow copy to the consumer. A copy of the completed PCRP will also be sent to the consumer's health care professional.

INSTRUCTIONS

Admission Date--Enter the date of initial admit.

Level I--Enter the date the Level I was approved by Mountain Pacific Quality Health Foundation. (Reminder: This date must be the same as or before the admission date.)

Level II--Check "No" if a Level II was not required. Check "Yes" if a Level II was completed. Mark "MR" for a Mental Retardation evaluation and "MI" for a Mental Illness evaluation. If both evaluations were completed, mark both boxes.

Date--Enter date(s) of completed evaluation(s). (Reminder: These date(s) must be the same as or before the admission date.)

Individual's Name--Enter the individual's name, address and telephone number.

Medicaid Number (SSN)--Enter the individual's Medicaid identification number.

Date of Birth--Enter the individual's date of birth.

Height--Enter the individual's height.

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Weight--Enter the individual's weight.

Sex--Enter M for male or F for female.

Marital Status--Enter the individual's marital status. (Single, married, divorced, widowed, or separated.)

Responsible Party--Enter the name, address and telephone number of the person responsible for the individual. This could be self, a spouse, relative, legal guardian, etc. Indicate the relationship to the consumer.

Attending Health Care Professional--Enter the name, address and telephone number of the individual's attending health care professional. The health care professional may be a M.D, nurse practitioner or physician assistant.

Residential Status--Enter the individual's residential status (private residence, with a spouse or relative, nursing facility, hospital, group residence, licensed personal care facility, adult foster home, or other--please specify).

Eligibility Category--Enter elderly or disabled.

Care Category--Enter appropriate level of care. Care Category 3 (CC3) plans require prior authorization.

Veteran--Enter "Yes" if eligible for veteran benefits. Enter "No" if not.

Date of Referral--Enter the date individual was referred for services. This is completed only on initial assessments.

Referral Source--Enter the name and telephone number of the individual or agency who referred the individual. This is completed only on initial assessments.

Interview Date--Enter the date the individual was interviewed. This is completed only on initial assessment.

Brief Description of Need for Service -- Summary statement describing primary reasons individual needs HCBS.

Medical Summary:

Medications and Allergies/ Diagnosis/ICD9 Code--Enter any known allergies of the individual. Enter the primary diagnosis and other diagnoses and medications pertinent to the HCBS service to be provided and the ICD9 Code for each.

Person-Centered Recovery Plan--List the home and community based services to be provided, the type of service provider and frequency.

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Discharge Date--The CMT must indicate a specific discharge date.

Signatures--Signatures of all individuals who participated in development of the Person-Centered Recovery Plan. All signatures must be dated.

This includes dated signatures of the following:

1. Individual - The individual must sign the plan unless unable to do so. An "X" is acceptable but must be co-signed by another person. The signature page of the care plan should contain a note explaining that the individual was unable to sign. No one should sign the individual's name on his behalf. If the individual has a legal representative, the representative must sign.

2. Health Care Professional - A health care professional (HCP) may be a physician, physician assistant certified, or a nurse practitioner. The signature of a health care professional is not mandatory, but can be requested at the team's discretion. In all instances, a copy of the completed Person-Centered Recovery Plan will be sent to the health care professional.

3. Case Management Staff--Only one member of the case management team is required to develop the SLTC-135B. This member must sign and date this care plan.